

MN Health Care Reform Access



DRAFT Minutes—July 23, 2012

Task Force Members Present

Commissioner Cindy Jesson (DHS), Donna Zimmerman for Mary Brainerd (HealthPartners), Ralonda Mason (St. Cloud Area Legal Services) CHAIR, April Todd-Malmlov for Commissioner Mike Rothman (Commerce), Representative Steve Gottwalt

Exchange Advisory Task Force Members Present

Sue Abderholden (NAMI), Phillip Cryan (SEIU)

Agency Staff Present

Lauren Gilchrist (Task Force Staff), Stefan Gildemeister (MDH), Jim Golden (DHS) LEAD, Trudy Ohnsorg (Task Force Staff), Beth Waldman (Bailit Health – Facilitator), Patrick Carter (Task Force Staff), Lindsay Carniak (Task Force Staff), Tina Armstrong (Commerce),

1. **Welcome:** Ralonda Mason opened the meeting at 9:03, and welcomed the members and guests.
2. **Minutes/Agenda:** The [minutes from June 21, 2012](#) were approved as written. A brief update on essential health benefits was added to the agenda.
3. **Update on the July 12 Task Force Meeting:** Ralonda Mason shared that the Task Force had assigned the Access Work Group the task of addressing the Medicaid expansion and that this task will be addressed at the August meeting. She then reviewed key comments from the [presentation of draft recommendations](#) to the Task Force:
 - Need to address how to minimize “churning” between plans
 - Need to provide an overview of how eligibility for public health insurance will change in 2014 compared to current programs
 - Eliminate co-pays for primary care, including mental health for the 138-205% FPL population.
 - The Work Group should be careful how health benefit options are described--avoid terms such as “basic” and “essential” and instead use terms such as “standard”
4. **Update on the Essential Health Benefits.**

Tina Armstrong presented on recent developments with EHB, including HHS final rule on metrics to determine the state’s default plan (the largest plan in the small group market). Based on these guidelines, a HealthPartners’ plan would become the state’s default for EHB if no action is taken to select a different plan. [A comparison of EHB benchmark options](#) including the HealthPartners product was provided. The health plans will be reporting data to US Dept of Health and Human Services between August 20th and September 4th 2012.

Work Group Discussion:

- We need to be clear about the implications for mental health services. Under mental health parity, non-quantitative limits are permitted
- The default EHB plan is only in effect for 2 years – from 2014 to 2016.
- It would be helpful to have public comments on the HealthPartners’ plan

- US DHHS will assess and supplement the default plan if there benefits missing from the ten required categories under the ACA, such as pediatric vision and oral care, habilitative care.
- The Certificate of Coverage for the default plan will be posted online as soon as its available. The definition of medical necessity should also be shared (but are not required to be reported under the federal regulations).
- The states three largest plans are very similar.

Public Comments:

Michelle Aytay, University of Minnesota College of Pharmacy, Minnesota Pharmacists Association, & Walgreens: Medical therapy management reimbursement should be included in the Essential Health Benefits.

Dr. Elizabeth Frost, Hennepin County Medical Center & Physicians for a National Health Program: Concerned about HealthPartners as the states' default plan because it has high deductibles and copays and these discourage people from seeking care. There are better alternatives than the small group product.

Charlie Mishek, Regions Hospital & MAARCH & MATD ([Written Testimony](#) and [Handout](#)): There are 23 million people with substance abuse disorders that could benefit from treatment but only about 10% of this population receives treatment. There is a \$1:\$7 return on investment from substance abuse treatment and, when all health care costs are included, the return on investment is \$1:\$12. We would like to see a model of substance abuse care that is not currently included in Minnesota Care. We also recommend the SBIRT (Screening, Brief Intervention, and Referral to Treatment). The \$10,000 hospital cap currently in Minnesota Care should be removed.

Kitty Westin, The Emily Program: There are 200,000 people with eating disorders in Minnesota and the resources to address their needs are not currently available but could be provided through outpatient care, inpatient care, or other methods. The treatment of eating disorders is fully included in insurance plans. Eating disorders should be named under medical benefits covered.

Discussion:

- The SBIRT and intervention coverage is included in the Prevention and Public Health Work Group Recommendation

5. Address other criteria for coverage for population at 138-205% of the Federal Poverty Line

Beth Waldman reiterated the work group process—that the group is not picking a vehicle for delivering these benefits, but rather is focused on determining what people need and build a vehicle around this aim. She then asked the Work Group to identify additional benefits beyond MinnesotaCare that they would like to have cost out for a wrap around and/or basic health plan. The base case is Minnesota Care as a base (with the \$10,000 hospital cap removed) with preventive services included at low or no cost. Specifically, what benefits should the Task Force staff cost out in order to find out their feasibility?

Discussion:

- Non-emergency transportation is needed in rural areas and for those with unreliable transportation in order to get to appointments. These benefits can be graduated (according to need and resources but specific criteria should be included, such criteria currently used in Medical Assistance.

- Eating disorder and substance abuse treatment should be included. DHS needs to look at how substance abuse treatment is currently funded and whether there may be potential savings from better coverage for these services in the benefit set.
- First episode coverage for mental health issues should be included – we tend to wait to treat mental health disorders. Sue Abderholden will provide more information on this topic.
- Anne Henry from the Disability Law Center provided [written comments](#) encouraging coverage of adult dental care, non-medical transportation, and personal care attendant services.
- MinnesotaCare does not provide much in terms of dental coverage, but if income is between 130% and 200% of the federal poverty line then individuals may apply for MA as well.
- Need to determine the percent of Minnesota Care participants that use personal care attendants and determine the level of need in this population.
- Could look at TEFRA (Tax Equity and Fiscal Responsibility Act) guidelines.
- The analysis should also consider how personal care attendants may reduce costs in the future and how these savings would be counted.

Public Comments:

Tony Larson, University of Minnesota College of Pharmacy: If it is not already included in MinnesotaCare, then Medication Therapy Management should also be considered.

The Task Force agreed that non-emergency transportation, eating disorders, substance abuse, dental coverage for adults, and personal care attendants should be cost out in the next Gruber-Gorman analysis and considered for inclusion in the benefit set for the 138-205 %FPL population. The group needs to confirm that medication therapy management is a covered service in MNCare.

6. Finalize the work group's other criteria for benefits for this population

Rolanda Mason asked the Work Group to consider factors other than affordability and benefits that would be important to include in coverage for people 130-200% of the Federal Poverty Line.

Discussion:

- The funding stream for providing coverage should have as much stability as possible.
- We should be open to different methods of prevention. How can access to benefits open doors to public health?
- There should be personal investment and involvement in one's own care. It is hard to translate things like wellness into public programs. DHS and MDH are working on a \$10 million federal grant to provide incentives for diabetes prevention in the MA population.
- In the Affordable Care Act, A or B grade preventive services are provided without copay.
- Minimize administrative complexity for state and individuals and minimize churn. If an individual's income rose above 200% FPL, how will we address the logistics of this or providing/changing products mid-year? We need to keep families together and enable continuity.
- Reducing disparities is as important as the quality of the services offered.
- The expectation that coverage is consistent and not complex makes it easier to enroll and operate and do outreach.
- Health literacy and health insurance literacy are important to develop.
- Data collection is important for disparities
- Culturally specific navigators are important. It is also important to have disparity measurement and convenience care (telehealth or mobile health).

Beth Waldman summarized the list of additional criteria for the 138-205% FPL coverage to include: stable funding stream for the coverage, encourage prevention/individual investment in personal health, minimize administrative complexity for enrollees and the state (including churn across programs), track and monitor disruptions in coverage for this population, cultural competency and health literacy, transparency regarding who is included in the coverage network (access to “convenience care”). It was decided that the list would not be prioritized.

Additional Comments/Discussion:

- The availability of providers based on reimbursement rates should be considered in the Gruber-Gorman analysis since the MA rate and private reimbursement rate differ greatly
- There is reimbursement rate variance by location and service. How does reimbursement affect access?
- Consider eliminating copays from primary care services.
- This discussion is broader than ACA preventive services. We should look at definition of “primary care” and specific services.
- The final report to the Task Force is due in September; this work group has two meetings in August. These meetings will include discussions of what happens to people who will not be covered in 2014 and considerations for the Medicaid Expansion.
- The safety net will exist because not participating in coverage creates other problems in the health care system. What mechanisms are needed to serve those without coverage?
- Undocumented individuals should be considered.

Public Comments:

Dr. Elizabeth Frost, Hennepin County Medical Center & Physicians for a National Health Program:
Cost sharing may increase participation but which if there was a comprehensive public program that reduces churn, clarified problems, provided extensive coverage, and reduced complexity? A public health insurance program would produce an average savings of \$1,200 to every family.

The meeting was adjourned at 10:56 a.m.